HCFA MEDICARE • MEDICAID
Health Care Financing Administration

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HEALTH watch

Medicare to Measure Error Rates of Private Contractors

Further strengthening its oversight of the private companies that pay and process Medicare claims, the Health Care Financing Administration (HCFA) announced an initiative to measure and track the payment accuracy for each of those companies.

In 1996, Medicare began using annual audits to determine a national error rate and has since reduced its error rate significantly. The new comprehensive error-rate testing program will establish baselines to measure each contractor's progress toward correctly processing and paying its share of the nearly one billion Medicare claims filed each year. Medicare will use the results to target efforts to pay correctly for services provided to its nearly 40 million beneficiaries.

The comprehensive error rates are the latest stop in HCFA's ongoing efforts to ensure effective management of these private contractors. Since Medicare was created in 1965, HCFA has been required by law to rely on private insurance companies to process Medicare claims. HCFA began a new initiative to strengthen its oversight of contractors in 1998, including:

• A new, high-level position to coordinate contractor oversight nationally, filled by a physician with experience fighting fraud, waste and abuse.

• A new national contractor performance evaluation strategy to ensure consistency and to focus on key contractors and high-risk areas.

• National teams to evaluate contractors' fraud and abuse efforts and other key functions, using standardized reporting and evaluation protocols.

• The development of additional, measurable standards, which will allow for more targeted reviews of specific areas of contractor performance.

• HCFA is also amending its contracts with these companies to ensure that they have plans to correct any financial-management issues raised in audits or other reviews.

The error-rate project also builds on the HHS Inspector General's efforts to measure the accuracy of Medicare's overall payments through its annual Medicare audit, which began in 1996. Since then, Medicare has increased its audits and medical reviews, worked with health-care providers to ensure appropriate documentation, and strengthened its education and outreach efforts. As a result, Medicare has significantly reduced its error rate.

HCFA will start its error-rate initiative this summer by determining error rates for its four Durable Medical Equipment Regional Carriers. These companies process nearly 50 million claims each year for medical equipment and supplies for beneficiaries nationally. Within a year, HCFA expects to perform similar evaluations for all its claims-processing contractors.

For each contractor, Medicare will conduct reviews for a statistically valid sample of claims and determine whether the contractor paid the claim accurately. The review will determine whether health-care providers were underpaid or overpaid for the sampled claims. The results will reflect not only the contractor's performance but also the billing practices of the health-care providers in their region.

The results will lead to a contractor-specific error rate that Medicare will track to promote improvements. Contractors would develop targeted corrective action plans to reduce payment errors through provider education, claims review and other activities.

HCFA will assign the work this spring to one of 13 special contractors selected last year specifically to help protect Medicare against waste, fraud and abuse. HCFA hired these special contractors, which have experience conducting audits, medical reviews and other program-integrity activities, under new authority obtained in the Health Insurance Portability and Accountability Act of 1996.

These error rates will guide claims-processing contractors as they work to improve their payment accuracy much as the Inspector General's audits have helped guide our efforts. Ultimately, they will boost our efforts to ensure Medicare claims are paid promptly and accurately.

—NANCY-ANN DEPARLE, HCFA Administrator

The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration (HCFA) to provide timely information on significant program issues and activities to its external customers.

MISSION —We assure health care security for beneficiaries.
VISION — In the stewardship of our programs, we lead the Nation's health care system toward improved health for all.
GOALS • Protect and improve beneficiary health and satisfaction • Promote the fiscal integrity of HCFA programs • Purchase the best value health care for beneficiaries • Promote beneficiary and public understanding of HCFA and its programs • Foster excellence in the design and administration of HCFA's programs • Provide leadership in the broader public interest to improve health.
OBJECTIVES — *Customer Service* • Improve beneficiary satisfaction with programs, services and care • Enhance beneficiary program protections • Increase the usefulness of communications with constituents, partners, and stakeholders • Ensure that programs and services respond to the health care needs of beneficiaries.
Quality of Care • Improve health outcomes • Improve access to services for underserved and vulnerable beneficiary populations • Protect beneficiaries from substandard care.
Program Administration • Build a high quality, customer-focused team • Enhance program safeguards • Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds • Increase public knowledge of the financing and delivery of health care • Improve HCFA's management of information systems/technology.

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You may browse past issues of the *HCFA Health Watch* at ***www.hcfa.gov/news/newsltrs/newsltr.htm***. Also, should you wish to make an address change or comment on an article, send your E-mail to ***healthwatch@hcfa.gov***.

Message from the Administrator

NANCY-ANN DEPARLE

NOT LONG AFTER I JOINED the Office of Management and Budget in 1993, one of the first things I heard was that the Medicare Trust Fund would go broke on our watch. That recollection makes the good news in the Medicare trustees report all the more remarkable.

Everyone at the Health Care Financing Administration is justly proud of the accomplishments of the past seven years. Medicare is alive and well and solvent for many years to come.

This is very good news for the American people — especially for the millions of seniors and disabled Americans relying on Medicare today and in the future — and for every HCFA employee.

The trustees project that the Medicare Part A Trust Fund, which pays for services provided Medicare beneficiaries in hospitals, skilled nursing facilities, hospices, and for some home health services, will remain solvent until the year 2025, based on the most probable economic and demographic assumptions.

This is far ahead of the 2015 depletion date predicted in last year's report and is the longest projection of solvency since 1974, more than two and a half decades ago. In the last seven years, we have extended the life of the trust a full 24 years, and we have cut the long-range actuarial deficit by 76 percent.

The trustees recommend that steps be taken to address the remaining long-range financial problems in the Part A Trust Fund. But these are cautionary notes in a report that otherwise contains very good news.

The new report credits the combination of a robust economy, as well as restrained expenditures due to HCFA's management of the program, and structural reforms accomplished by the Balanced Budget Act, for extending the life of the trust fund and cutting the projected actuarial deficit by over three fourths.

As Secretary Donna E. Shalala said, "We must keep working for a consensus on how to protect and modernize Medicare. We must keep the promise that we made 35 years ago to America's senior citizens. And we must keep the promise in the future."

I am proud of the hard work and long hours by HCFA employees who have helped implement many of the changes that have made this success possible. They have learned important lessons from the private sector and made them work for beneficiaries and taxpayers.

HCFA employees have demanded more accountability, cut waste, and strengthened Medicare through a vigorous campaign against fraud and abuse. While keeping in mind that most health care providers are honest and are seeking to give the best care to Medicare's beneficiaries, HCFA is stopping the unscrupulous ones.

The agency has implemented scores of reforms — from payment changes to preventive services — in the bipartisan Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999. The hard work of the HCFA staff, and its partners in other agencies and in the Congress, has made Medicare a stronger program.

Selected Health Issues on the *Web*

http://newfederalism.urban.org/pdf/occa33.pdf

The Role of TennCare in Health Policy for Low-Income People in Tennessee
BY CHRISTOPHER J. CONOVER AND HESTER H. DAVIES

"...A considerable amount of anger, resentment, and distrust has built up on the part of providers. In this milieu, it is easy to lose track of the fact that much good has been achieved by TennCare. The program has increased coverage of many who would otherwise be uninsured, including those deemed uninsurable by private insurance plans. There is also considerable evidence that access to care has improved, emergency room visits have fallen, and utilization of many preventive health services has increased..."

http://books.nap.edu/catalog/9612.html

Safety-Net Health Providers Are in Trouble:
America's Health Care Safety Net: Intact But Endangered
BY THE COMMITTEE ON THE CHANGING MARKET, MANAGED CARE, AND THE FUTURE VIABILITY OF SAFETY NET PROVIDERS, INSTITUTE OF MEDICINE

The committee concludes that the safety-net system is a distinct delivery system. However, imperfect, it addresses the needs of the nation's most vulnerable populations. In the absence of universal insurance coverage and while the new market paradigms are unfolding, it seems likely that the nation will continue to rely on safety-net providers to care for its most vulnerable and disadvantaged populations.

http://www.gao.gov/new.items/h600087t.pdf

Medicaid in Schools:
Poor Oversight and Improper Payments Compromise Potential Benefit
T-HEHS/OSI–00–87, April 5, 2000

Statement of Kathryn G. Allen, Associate Director, Health Financing and Public Health Issues, and Robert H. Hast, Acting Comptroller General for Special Investigations before the Committee on Finance, U.S. Senate.

Mammogram Ad Published in *Better Homes and Gardens*

As a public service, the April 2000 edition of *Better Homes and Gardens* magazine published an advertisement on *Mammograms — Not Just Once But For A Lifetime*. *Better Homes and Gardens* is a national magazine that has a monthly publication of 7.5 million copies, and the HCFA ad ran in 1.3 million of them.

This specific mammogram ad is part of HCFA's ongoing campaign to inform women that Medicare helps pay for yearly mammograms. HCFA's National Mammography Campaign is working toward the goal of increasing biennial mammography rates for Medicare women 65 and older, to increase awareness of the Medicare mammography benefit among women and to educate providers about the importance of referring older women for regular mammograms. A woman's risk of getting breast cancer increases with age, but early detection of the cancer helps save lives and can improve the quality of life after treatment.

Mammograms — Not Just Once But For A Lifetime is a national initiative, which assists women in obtaining information about Medicare coverage for mammography services. Inclusive are:

• A national toll-free phone number, **1-800-MEDICARE**, to provide answers about mammograms and Medicare.

• Another national toll-free phone number, **1-800-4-CANCER**, to direct women to the National Cancer Institute's Cancer Information Service.

Betty Burrier, a health insurance specialist in HCFA's Center for Beneficiary Services, contributed this article.

Competition to Help Medicare Protect Quality, Reduce Medical Supply Costs in San Antonio

Medicare will begin using competition to pay more reasonable prices for quality medical equipment and supplies in the San Antonio area, launching a pilot project that could save beneficiaries 17 percent in out-of-pocket costs.

The competitive-bidding project, authorized by the Balanced Budget Act of 1997, will operate in three Texas counties — Bexar, Comal and Guadalupe — starting in January 2001. The project uses private-sector competition to establish prices for certain medical supplies while protecting quality and access for seniors and disabled people who receive Medicare benefits.

HCFA will conduct a thorough review of the quality and backgrounds of bidders. Only those businesses that demonstrate their ability to provide quality supplies and services to beneficiaries at competitive rates will be offered contracts in the pilot.

Studies have shown that under fee schedules required by law, suppliers have been able to charge beneficiaries higher prices than those charged at many retail outlets, and some other government payers and private insurers pay much lower rates.

For example, the HHS Inspector General found that Medicare allowances for albuterol sulfate, a nebulizer inhalation drug, were more than three times suppliers' acquisition costs. The drug could also be purchased through mail-order and retail pharmacies for substantially less than Medicare paid. For semi-electric hospital beds, other insurers paid at least 14 percent less than Medicare did for monthly rentals.

Design of the demonstration:	
Ensure	that Medicare beneficiaries obtain medical equipment from suppliers who have been carefully screened and have met or surpassed Medicare's quality standards;
Enable	beneficiaries and the Medicare program to pay more reasonable rates for equipment than the fee schedules required by law;
Ensure	that beneficiaries can choose their preferred supplier from those companies that submitted successful bids in terms of quality and price. Multiple suppliers will be selected for each product category, giving beneficiaries a choice; and
Ensure	that beneficiaries are not overcharged for their share of the costs. Suppliers must accept a 20 percent co-payment for those supplies and services without any additional charges to the beneficiary.

Suppliers in the three counties will compete this spring on quality and price for five categories of medical supplies. The categories are oxygen, supplies, hospital beds, manual wheelchairs, non-customized orthotic devices (including "off-the-shelf" items such as braces and splints, and albuterol sulfate and other nebulizer inhalation drugs, which are used to treat lung disease and other conditions. Medicare expects to begin paying under the pilot in January 2001.

The Clinton Administration has asked Congress repeatedly for the authority to move to a more competitive pricing system. The President again proposed this type of reform in 1999 as part of his plan to modernize and strengthen Medicare and as part of his fiscal year 2001 budget.

Medicare began its first competitive-bidding pilot in Polk County, Fla., in October 1999. In the florida pilot, suppliers submitted bids to provide five types of medical supplies to beneficiaries. Medicare selected as many as 13 businesses in each category and established a new fee schedule.

Overall, the savings averaged 17 percent across all five product categories, and the savings were as high as 30 percent for some products. The competition resulted in slightly higher prices for some individual items, primarily in the small category of surgical dressings.

HCFA is also using feedback and analysis of the Florida pilot to make improvements to better serve beneficiaries, suppliers and Medicare in the San Antonio pilot. It involves some different product categories. It involves supplies for beneficiaries in original fee-for-service Medicare, but not for those in Medicare+Choice plans.

The San Antonio project continues significant protections, including a broad emphasis on quality:

- **Quality Standards:** Medicare will conduct site visits and background checks to ensure that successful bidders have solid track records of providing quality supplies and services. Suppliers who fail this quality review — which is even more stringent than Medicare's existing standards — will not be selected even if they bid in the competitive range.

- **Beneficiary Choice:** Medicare will select enough suppliers for the demonstration to ensure access to services and a choice of suppliers. In Polk County, between four and 13 companies were chosen in each of five product categories.

- **Information Campaign:** Medicare will conduct a comprehensive education and outreach campaign — in English and Spanish — for beneficiaries, physicians and suppliers. Every beneficiary will receive a directory of demonstration

suppliers and a clear explanation of changes in Medicare rules.

• **Custom-made Products:** The demonstration will not include any custom-made products, which must be fitted for individual beneficiaries. Beneficiaries will continue to be able to purchase such equipment from any supplier under existing Medicare policies.

• **Local Ombudsman:** An ombudsman in San Antonio will respond to beneficiary concerns and monitor the project to make sure beneficiaries continue to receive quality supplies and services.

• **Transition Protections:** Beneficiaries will be able to maintain their existing relationships with suppliers of oxygen and inhalation drugs, and continue rental agreements for hospital beds and wheelchairs. Also, beneficiaries with non-customized braces and other orthotic equipment can continue to rely on the original provider for repairs and services.

The San Antonio region was selected for this demonstration because it has enough suppliers and people to create the potential for significant savings for both beneficiaries and the Medicare program. About 112,000 senior citizens and disabled residents in the three county area receive Medicare benefits. In 1998, Medicare paid an average of $287 per beneficiary for medical equipment and supplies. Between 15 and 48 suppliers provided at least $10,000 in services to the region's Medicare beneficiaries in each of the five product categories included in the project.

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In the Limelight

Sallyjo Wieling Honored for Helping Elderly, Disabled People Get Better Nursing Home Care

Sallyjo Wieling, a La Grange, Ill., resident and health insurance specialist in the Health Care Financing Administration's Chicago Regional Office, received the U.S. Department of Health and Human Services' outstanding employee award for February from HHS Secretary Donna E. Shalala and HCFA Administrator Nancy-Ann DeParle.

Sallyjo Wieling

Wieling works with nursing home inspectors and health care providers for HCFA. She helps to ensure providers give the most appropriate care to meet the needs of Medicare and Medicaid beneficiaries who reside in nursing homes and other long-term care facilities.

"Sallyjo is an expert on the quality of long-term care received by beneficiaries in the Chicago region and elsewhere," DeParle said. "She also is a valuable resource for the senior staff when an issue involving our most vulnerable citizens needs to be resolved."

A 20-year HCFA employee, Wieling serves on a committee with state government representatives and health care providers to share innovations for improving quality in nursing homes. She also was a member of the national task force on restraint reduction, which aims to maintain the quality of life and improve safety in nursing homes without using patient restraints.

Wieling has served as the Chicago region's coordinator for the Program of All-Inclusive Care for the Elderly (PACE), which enables the frail elderly to stay in their communities to receive the care they need, instead of moving into a nursing facility. This option for Medicare and Medicaid beneficiaries integrates in one setting all the medical services needed for those who otherwise would be in a nursing home. The goal of PACE is to keep people independent and living in their community, and provide quality, cost-effective integrated care.

The Balanced Budget Act of 1997 established PACE as a permanent Medicare program and a state option under Medicaid. To participate in a PACE project, an individual must be at least 55 years old, live in the PACE program's service area and be certified as eligible for nursing home care by an appropriate state agency.

The Clinton Administration has made ensuring the health and safety of nursing home patients a top priority. As part of this ongoing commitment, HCFA now requires states to crack down on nursing homes that repeatedly violate health and safety requirements. HCFA also has given consumers ready access to comparative information about nursing home quality and is changing the inspection process to increase its focus on preventing bedsores, malnutrition and resident abuse.

"No one in the regional office has done more over the years to improve the quality of life for Medicare and Medicaid beneficiaries in the long-term care setting," said Dorothy Collins, HCFA Regional Administrator in Chicago. "Whether as a federal surveyor performing onsite inspections of nursing homes, or as a nationally recognized consultant on federal quality of care initiatives, Sallyjo never says 'no' to a challenge."

New Medicare Hospital Outpatient Payment System Established

In late March, HCFA announced a new Medicare payment system for hospital outpatient services designed to encourage more efficient delivery of care and to ensure more appropriate payment for services by Medicare and its beneficiaries.

Over time, the regulation will save beneficiaries millions of dollars in co-insurance payments for outpatient services. In addition to hospital outpatient services, the new prospective payment system will apply to partial hospitalization services furnished by community mental health centers.

The final regulation, published on April 7 in the *Federal Register*, carries out the payment changes initially proposed by the Clinton Administration, which were enacted in the Balanced Budget Act of 1997 and adjusted in the Balanced Budget Refinement Act of 1999. The proposed regulation was open for comment by individuals and organizations between its publication in September 1998 and July 1999.

HCFA will implement the new payment system, expected to go into effect on July 1, 2000. The provisions for provider-based facilities owned by hospitals, including physician office practices, will be effective six months from the publication date.

HCFA will make certain that hospitals and their billing companies have the information and training they need to carry out system changes for the new outpatient prospective payment system. The agency will also monitor the progress of hospitals as they make the necessary changes and will continue to work closely with the hospital associations.

The new payment system is based on ambulatory payment classifications (APC), which divides all outpatient services included in the new payment schedule into 451 groups. The services within each group are clinically similar and require comparable resources.

A key provision of the 1997 budget law is a change in beneficiary co-insurance payments. The current co-insurance is based on 20 percent of charges billed by the hospitals and community mental health centers. In fact, for many out-patient services, beneficiaries pay 50 percent or more of the total payment to the hospital for outpatient treatment.

The Clinton Administration has long advocated reducing co-insurance that beneficiaries must pay for hospital outpatient services. In 1997, the administration's budget proposed to reduce co-insurance for beneficiaries to 20 percent of Medicare payment rates by 2007. Congress adopted a variation of the President's proposal in the 1997 budget law.

Co-insurance amounts will be frozen until the co-insurance payment for an APC becomes 20 percent of the total payment. Once co-insurance becomes 20 percent of the total payment, both the Medicare payment and the co-insurance amount will be updated annually so that co-insurance will continue to be 20 percent of the total payment. The actual co-payment amounts for an APC will be limited to the Medicare hospital inpatient deductible, which for 2000 is $776. In addition, hospitals have the option of reducing the co-payment.

The APC payment rate established for each group applies to all services within the group. Although national payment rates are established for each group, payments will be wage adjusted to reflect geographic differences. Under the final rule, HCFA has developed separate APCs to pay for blood, other blood products and anti-hemophilic factors.

In addition, HCFA modified the proposed regulation to allow a smoother transition to the new fee system for providers. The APC groups were refined based on comments. The changes included paying for corneal tissue temporarily at its acquisition cost rather than as part of the payment for overall corneal transplant surgery, and requiring the use of HCPCS codes only for purposes of computing payments for medical visits to clinics and emergency departments.

The regulation excludes ambulance services because a new fee schedule is being developed. Physical, occupational and speech therapies, orthotic and prosethetic devices, durable medical equipment and clinical laboratory services are excluded because they are paid under existing fee schedules.

The final rule incorporates changes in hospital outpatient payments set by the 1999 budget law including:

- Medicare will make additional payments for certain new medical devices and drugs for up to three years.
- During a transition period until 2004, Medicare will pay hospitals a portion of any losses they would otherwise incur resulting from smaller payments than under prior law. For rural hospitals with 100 or fewer beds, these losses will be fully replaced.
- Medicare will make an outlier payment for high-cost cases, with payments projected not to exceed 2.5 percent of total payments to hospital outpatient departments in 2000-2003.
- Certain cancer hospitals will be protected permanently from any reduced Medicare payments.
- Medicare will pay for implanted medical devices under the new payment system, rather than under a medical equipment fee schedule.
- HCFA will annually review the APC groups, wages and other adjustments. As part of this review, HCFA will consult with an expert panel composed of provider representatives.

A 60-day comment period in the final regulation applies only to the regulatory changes resulting from the 1999 budget law.

The new regulation also addresses the criteria a facility must meet to be designated "provider-based." In recent years, provider-based facilities have expanded, including an increase in hospitals acquiring physician office practices to use as hospital outpatient departments. The regulation also includes requirements for hospitals to furnish an appropriate level of physician supervision in off-site clinics.

Visit www.organdonor.gov to learn more about organ and tissue donation

Medicare Toll-Free Line Commemorates First Anniversary

More than 1 Million Calls Have Been Received at 1-800-MEDICARE (1-800-633-4427)

In just 12 months, more than 1.5 million callers — Medicare beneficiaries and the people who help them with their health care decisions — have used America's new telephone number for Medicare information.

Established by HCFA in 1999, the Medicare Choices Hotline is available throughout the United States and is the only national toll-free phone line that provides up-to-date information about Medicare.

"Callers to 1-800-MEDICARE tell us this service really helps them get answers to their questions about Medicare," said HCFA Administrator Nancy-Ann DeParle. "They like the information they are getting, and they like having a wide range of options on how to get that information.

"Beneficiaries who have called 1-800-MEDICARE have told us they like talking to a person who can answer their questions," said DeParle. "They also want to be reassured that if they are happy with how they currently get their health care, they don't have to make any changes at all."

HCFA phased in the toll-free telephone line across the country between January and March 1999, and was fully operational throughout the country on April 1, six months ahead of schedule. Today 1-800-MEDICARE (1-800-633-4227) averages about 75,000 calls each week. Most callers request information about the availability of managed care plans in their community, followed by requests for Medicare publications.

Callers to 1-800-MEDICARE (1-800-633-4227) can talk to a customer service representative in English or Spanish between 9 a.m. and 4:30 p.m. local time, Monday through Friday, to get :

- general information about Medicare;
- general information about Medicare health plan options in their community, including original fee-for-service Medicare and, where available, managed care;
- specific quality and satisfaction information about available managed care plans;
- general information about Medicare supplemental insurance (Medigap); and
- telephone numbers for help with a variety of related issues, such as billing questions about Medicare claims or for help with more complex questions about health insurance.

HCFA created the national Medicare & You information program to provide information resources to help Medicare beneficiaries better understand Medicare. Medicare & You includes expanded and updated print materials such as the *Medicare & You* handbook and other topic-specific publications, the toll-free telephone line, and the beneficiary-oriented Internet web site — ***www.medicare.gov*** — as well as a coordinated partnership program with more than 200 national and local organizations who work with Medicare beneficiaries and their caregivers. The program also includes an extensive evaluation component designed to help HCFA learn from beneficiaries and the people who help them with their health care decisions about how they want to receive information about Medicare.

The Medicare consumer web site, unveiled in June 1998, had more than 1.3 million page views in February 2000 and its usage continues to grow. The most-visited sections are Medicare Compare and Nursing Home Compare. Medicare Compare has up-to-date comparative information about Medicare managed care plans that are available across the country. Nursing Home Compare includes information about individual nursing homes. New features at ***www.medicare.gov*** include Medigap Compare and an outreach calendar that lists more than 3,000 health fairs, meetings and presentations that are being held all across the nation. Medicare publications can also be downloaded from the web site.

Medicare is the nation's largest health insurance program and covers almost 450 million Americans over 65 and certain people with disabilities in original fee-for-service Medicare and the Medicare+Choice program. In fiscal year 1999, HCFA spent an estimated $288 billion to finance health care services to elderly and disabled Americans in the Medicare and Medicaid programs.

"Nearly 40 million Americans depend on Medicare for the health care they deserve," DeParle said. "They should have as many choices as possible — in their care and the information they receive about Medicare."

1-800-MEDICARE *is just one place where Medicare beneficiaries can get information about their Medicare. In addition to the Helpline, beneficiaries can get information from the* Medicare & You *handbook,from* ***www.medicare.gov*** *or from the hundreds of local and national organizations who work with Medicare beneficiaries.*

—Carol Cronin, Director, Center for Beneficiary Services

New Regulations/Notices

CLIA Program; Cytology Testing [HCFA–2233–N] — Published 3/17. This document announces the withdrawal of a proposed rule on cytology proficiency testing that was published in the Federal Register November 30, 1995 [60 FR 61509]. HCFA published the proposed rule to comply with a court order that HCFA revise the regulations to require that cytology proficiency testing (PT) be conducted, "to the extent practicable, under normal working conditions," which the court interpreted to be at a pace corresponding to the maximum workload rate for individuals examining cytology slides. After the proposed rule was published, the appeals court overturned the lower court's ruling and remanded the regulation to HCFA for completion of rulemaking or to provide HCFA's rationale for the original position it took with respect to cytology proficiency testing. This document withdraws the proposed rule and also contains a supplementary statement of rationale, in accordance with the appeals court ruling. This proposed rule is withdrawn as of April 17, 2000.

Medicare Program; Coverage of, and Payment for, Paramedic Intercept Ambulance Services [HCFA–1813–F] — Published 3/15. This final rule responds to public comments received on a final rule with comment period published on January 25, 1999 that implemented section 4531(c) of the Balanced Budget Act of 1997 concerning Medicare coverage of, and payment for, paramedic intercept ambulance services in rural communities. It also implements section 412 of the Medicare, Medicaid, and State Children's Health Insurance Programs' Balanced Budget Refinement Act of 1999 by adding a new definition of a rural area. These regulations became effective on April 14, 2000.

Medicare Program; Negotiated Rulemaking: Coverage and Administrative Policies for Clinical Diagnostic Laboratory Services [HCFA–3250–P] — Published 3/10. This proposed rule would establish national coverage and administrative policies for clinical diagnostic laboratory services payable under Medicare Part B to promote Medicare program integrity and national uniformity, and simplify administrative requirements for clinical diagnostic laboratory services. A Negotiated Rulemaking Committee developed the proposed policies as directed by section 4554(b)(1) of the Balanced Budget Act of 1997. Comments will be considered if HCFA receives them at the appropriate address, as provided below, no later than 4 p.m. on May 9, 2000. Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–3250–P, P.O. Box 8016, Baltimore, MD 21244-8016.

Calendar of Events — May and June 2000

May 16 — Administrator Nancy-Ann DeParle addresses the AARP's Celebration 2000 in Orlando, Fla., on *How Will Changes to the Program Impact Current and Future Beneficiaries in the New Millennium?*

May 19 — Deputy Administrator Michael Hash speaks at Duke University's National Forum on *Health Affairs in Durham, N.C., on The Government Overview.*

May 24 — Administrator DeParle speaks at the Center for Corporate Innovation (CCI) in Chicago, Ill., on *An Update on HCFA.*

June 25 — Administrator DeParle speaks at the HCFA and Department of Justice Fraud Conference entitled Combating Health Care Fraud and Abuse: Technologies and Approaches for the 21st Century in Crystal City, Va., on *HCFA's Interests and Issues.*

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